Maternal Health Psycho/Social Assessment

Client ID: _____

Admission ID: _____

Client's name *(first, middle, last)*: _____ Maiden name: _____

Birth date: ____/____/____ Client alias: _____

Street address: _____ Apt# _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Alternate phone: _____

Contact date: _____/_____/_____ Time in: _____ Time out: _____ ☐ Initial visit

Who was present: _____

Location: _____

Goal: _____

Narrative: _____

_____

_____

Affect:

☐ appropriate to content ☐ labile
☐ blunted ☐ restricted
☐ flat ☐ other
☐ inappropriate Comments _____

Mood:

☐ angry ☐ euphoric ☐ other
☐ anxious ☐ frightened
☐ depressed ☐ irritable
☐ elevated ☐ normal Comments _____

Dress:

☐ appropriate ☐ other
☐ unclean
☐ unkempt
☐ unusual Comments _____

Hygiene:

☐ adequate ☐ other
☐ good
☐ neglected
☐ poor Comments _____

Suicidal ideation: ☐ reported ☐ observed ☐ other

Self harm: ☐ yes ☐ no

Homicidal: ☐ yes ☐ no

EPDS Completed: ☐ yes ☐ no

Mental health comments:_____

_____

Client Name: _____ Birth Date: _____Medicaid ID: _____

Risks:

☐ Death of a loved one	☐ Hx of mental health issues	☐ Poverty
☐ Depression	☐ Hx of miscarriage	☐ Recent change or job loss
☐ Divorce	☐ Hx of physical abuse	☐ Recent major move
☐ Domestic violence	☐ Hx of sexual abuse	☐ Relationship with father
☐ Drug and/or alcohol use	☐ Hx w/Child Protection	☐ Relationship with mother
☐ FOB unsupportive of pregnancy	☐ Inability to imagine baby	☐ Relationship with spouse
☐ Homelessness	☐ Loss	☐ Specific cultural issues
☐ Hx of eating disorder	☐ Older mother (over 35)	☐ Suicidal behavior
☐ Hx of emotional abuse	☐ Past/present criminal Involvement	☐ Trauma
☐ Hx of infertility	☐ Poor attachment history	☐ Young mother (under 16)
☐ Hx of living in foster homes	☐ Poor physical health	

Risk comments:_____

_____

Patterns of Functioning

Support system:_____

_____

Financial needs/concerns:_____

_____

Current living situation:_____

_____

Family Interaction at Contact

Name	Relationship	Living w/client	Birthdate	Age	Interaction	Comments
					☐ fair ☐ good ☐ poor	
					☐ fair ☐ good ☐ poor	
					☐ fair ☐ good ☐ poor	
					☐ fair ☐ good ☐ poor	

Adjustment to pregnancy and future parenting:_____

Plan of care: _____

_____

Counseling/anticipatory guidance:_____

_____

Referrals:

☐ clothing agency	☐ HIV testing	☐ shelter
☐ dental services	☐ housing assistance or referral	☐ social service agency
☐ Early Childhood services	☐ income maintenance	☐ substance abuse
☐ Early HeadStart/HeadStart	☐ job or job training	☐ WIC
☐ education	☐ Listening Visits	☐ unknown
☐ family planning	☐ medical services	☐ other
☐ food pantry	☐ mental health	Specify_____
☐ health insurance	☐ nutritional counseling	

Follow up visit date: _____ Follow up comments: _____

_____

	Name	Date
Form completed by:		
Data entered by:		
Quality assurance inspection:		